REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

NOTE: This form is to be used **after** an inquest.

	REGULATION 28 REPORT TO PREVENT DEATHS **THIS REPORT IS BEING SENT TO:** **The Ministry of Justice** **Death Management, Miscarriages of Justice Enquiries and Coroners** **5 Wellington Place** **Leeds** **West Yorkshire LS1 4AP** [redacted]
1	**CORONER** I am Mrs D HOCKING, His Majesty's Assistant Coroner for the coroner area of Leicester City and South Leicestershire.
2	**CORONER'S LEGAL POWERS** I make this report under paragraph 7, Schedule 5, of the Coroners and Justice Act 2009 and regulations 28 and 29 of the Coroners (Investigations) Regulations 2013.
3	**INVESTIGATION and INQUEST** On 24 September 2024 I commenced an investigation into the death of Nigel Anthony FECKEY aged 64. The investigation concluded at the end of the inquest on 23 January 2026. The conclusion of the inquest was Suicide The jury recorded the following at Part 3 of the Record of Inquest:- HMP Fosseway opened in 2023 it was designed to be run on an Offence-Neutral basis with all prisoners mixing freely on the wings and in communal areas such as education. There was no provision for segregation of prisoners by age, offence, or vulnerability. Several weeks before Nigel's death an over 50's wing was created and Nigel was moved there. Subsequent to Nigel's death, a wing for vulnerable prisoners was created and 700 of the prisoners were moved there. During his incarceration, Nigel was moved 6 times to take him away from abusive prisoners. The prison population was at near capacity with approximately 1700 inmates of which 700 were sex offenders. Custodial staffing was a challenge. The majority of the staff were inexperienced. For many, it was their first job in the prison service. A 'Tiger Team' of experienced officers was deployed to provide additional 'on the job' training and support. It was common for shifts to start without the required number of staff. Staff in supervisory/managerial roles, such as Custodial Operations Managers (COM's), spent much of their time and effort managing staff shortage issues. COM's often carried out the role of a Prison Custody Office (PCO) to fill gaps. SERCO admitted that contrary to his training, the prison custody officer failed to undertake a roll count and welfare check at 22.00 on 22 September 2024 and at 06.00 on 23rd September 2024 but these failures did not more than minimally, trivially or negligibly cause or contribute to Nigel's death. SERCO also admitted that

contrary to his training, the custodial operations manager coordinating Nigel's ACCT (Assessment, Care, Custody, Teamwork) document failed properly to record the details of the reviews conducted on 27th June 2024, 5th July 2024 and 11th July 2024. But these failures did not more than minimally, trivially or negligibly cause or contribute to Nigel's death. The organisation of staff was complex with different roles looking after different aspects of a prisoner's life. Custodial and Healthcare staff had different employers. Teamwork was essential for the safe and effective running of the prison. The term 'Multi-Disciplinary-Team' was used in ACCT documentation but the term was not defined and was open to interpretation which adversely affected the effectiveness of the ACCT process. The ACCT post-closure process was not followed correctly for Nigel and opportunity was missed to fully consider whether the ACCT should be reopened. Bullying, verbal and physical abuse was common throughout the prison. The high number of sex offenders, the offence neutrality of the prison and the inexperience of staff made it extremely difficult to control this. Nigel was subjected to bullying, verbal and physical abuse since his admission to prison – he had items stolen from his cell. He should have been provided with a privacy key to enable him to secure his cell when he was not in it. There were occasions when this key was not provided and this added to Nigel's anxiety. He frequently reported such incidents and staff were well aware of his situation and it's impact on him. Some reported incidents were not investigated thoroughly due to lack of supporting CCTV (Closed Circuit Television) footage. On 21 March 2024 a prisoner entered Nigel's cell and threw a kettle of boiling water at him. A thorough physical examination to establish the extent of any injuries was not carried out at the time. The incident was not reported to the police. The police were only informed months later when Nigel wrote to Wigston Police Station to report the incident. Investigations were due to commence shortly after his death. There were many paper and computer based systems in place. These were siloed in nature and owned by different entities. Interoperability of these disparate systems was essential for the safe and effective running of the prison. The flow of information between Custodial and Healthcare staff was restricted in order to comply with confidentiality requirements, these systems relied heavily on information sharing and teamwork to run effectively. There were deficiencies in both of these aspects. Nigel struggled to form close relationships with prison staff. He moved cell regularly and therefore didn't form a close relationship with his key worker. His closest and most consistent relationship was with a Prison Offender Manager based in the Operations Management Unit (OMU). His last communication was an email to this officer on Saturday 21st September 2024. This message was not seen as the OMU was not manned at the weekend. It is probable that an ACCT would have been opened immediately if this message had been seen before Nigel's death. From the start of his sentence, Nigel made it clear to Custodial and Healthcare staff on numerous occasions that he couldn't cope with life in Fosseway Prison – he felt anxious and unsafe. He felt that his calls for help were being ignored. SERCO admit that Nigel sent an app from the kiosk to Neurodiversity, managed by SERCO, on 31st August 2024 asking for someone from Mental Health to contact him soon and this message was not passed to Healthcare or otherwise responded to but that this failure did not more than minimally, trivially or negligibly cause or contribute to Nigel's death. Nigel's sister was well aware of his situation and the effect it was having on his mental health. She was a great advocate and used every avenue open to her to express her concerns verbally an in writing to the prison. She wrote to the Prison Governor on 6th August 2024 and 16th September 2024 expressing her concerns. She received no response. Nigel clearly expressed a desire to be transferred to a category D (open) prison where he would be better able to serve out his sentence. He did not clearly understand the pathway to such a move. When he was enrolled on the necessary courses, he could not access them due to long waiting lists. He was under the impression that he would need to move cell block in order to complete a necessary course – he believed that this would expose him to physical danger. Prison staff did not correct his misunderstandings and did not allay his unfounded fears. In conclusion, Nigel was primarily let down by the custodial system. Staff were generally conscientious and well-meaning but circumstances dictated that they could not carry out their duties to the required standard.

The cause of death was established as:

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4	**CIRCUMSTANCES OF THE DEATH** Mr Feckey was found suspended by a ligature in his prion cell at HMP Fosse Way on the 23 September 2024. He was declared deceased at the scene.
5	**CORONER'S CONCERNS** During the course of the investigation my inquiries revealed matters giving rise to concern. In my opinion there is a risk that future deaths could occur unless action is taken. In the circumstances it is my statutory duty to report to you. The **MATTERS OF CONCERN** are as follows: Mr Feckey was a Prisoner Convicted of a sexual offence (PCOSO). Offence Neutrality is when there is no special block to keep sex offenders in, and the population is mingled regardless of the offence they are in prison for. It was discussed at the inquest and concluded in evidence that it is not possible to keep offences secret for the most part because although the prisoners have no access to the wide internet themselves in their cells, they only have to ask someone on the phone or at a visit to find out what someone is in for and it can be that easy. Also heard at the inquest was that many mainstream prisoners held strong views that they did not wish to share their living space with men convicted of sex offences. They were both vocal and physical in their resistance to integrated living. The data at Fosse Way suggested that a change was required as figures for self-harm and self-isolation were beginning to emerge. Although steps were taken to encourage integration a reassessment of this position took place in early 2025 and decision was made to separate the residential houseblocks and In March 2025 700 prisoners from the prison were transferred to a non-integrated unit. Since then, there had been a reduction in the number of ACCT documents and self-isolation. Evidence in the inquest indicated that sex offender prisoners were scared, they felt they couldn't leave their cells and that they were vulnerable to direct bullying or verbal abuse. Shouting and threats were constantly heard directly connected to the PCOSO offences. Whilst Fosse Way have taken their own risk reductions regarding offence neutrality, I understand that the policy remains and is still implemented in other prisons and it is a matter of concern to me that a future death may occur.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you (and/or your organisation) have the power to take such action.
7	**YOUR RESPONSE** You are under a duty to respond to this report within 56 days of the date of this report, namely by March 25, 2026. I, the coroner, may extend the period. Your response must contain details of action taken or proposed to be taken, setting out the timetable for action. Otherwise, you must explain why no action is proposed.
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	COPIES and PUBLICATION I have sent a copy of my report to the Chief Coroner and to the following Interested Persons: I have also sent it to: The Family solicitors Serco UK solicitors Notts Healthcare NHS Foundation Trust Thompson's solicitors Practice Plus group [redacted] who may find it useful or of interest. I am also under a duty to send a copy of your response to the Chief Coroner and all interested persons who in my opinion should receive it. I may also send a copy of your response to any person who I believe may find it useful or of interest. The Chief Coroner may publish either or both in a complete or redacted or summary form. He may send a copy of this report to any person who he believes may find it useful or of interest. You may make representations to me, the coroner, at the time of your response about the release or the publication of your response by the Chief Coroner.
9	**Dated: 28/01/2026** [redacted] **Mrs D HOCKING** **His Majesty's Assistant Coroner for Leicester City and South Leicestershire**